Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INJURY REHAB CLINIC
10610 FONDREN ROAD SUITE 124
HOUSTON TX 77036

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
March 13, 2012

Respondent Name
METROPOLITAN TRANSIT AUTHORITY

MFDR Tracking Number
M4-12-2352-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following claim (s) is being resubmitted for a dispute resolution because it was denied by the carrier for services not being authorized and also stating that the treatment falls outside of the ODG guidelines. In a recent conversation I spoke with a representative with ODG and they explain that services that are not listed as considered as 'Exception to the DOG Guidelines. This patient had multiple injuries. Her treatment included physical therapy and chiropractic manipulation. It was documented throughout the patient treatment plan that she had signs of improvement and relief. Also, please note that some of these services that the insurance carrier denied did not require authorization such as office visits which are services listed as codes for automated approval according to ODG."

Amount in Dispute: $2,540.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "STARR Comprehensive Solutions, Inc., provided a response [to the requestor, not DWC] dated 3/22/12 (copy attached). That response articulates the rationale underlying the EOB denials."

Response Submitted by: Flahive, Ogden & Latson, P. O. Box 201320, Austin, TX 78730

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 21, 2011 to November 14, 2011	73100, 73562, G0283-GP-59, 97012-GP-59, 97035-GP-59, 98943-GP-59, 98941-GP-59, 99212-25-59	$2,540.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting an Independent Review Organization (IRO).
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 12, 2011
- W1 – Workers Compensation State Fee Schedule Adjustment
- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 50 – These are non-covered services because this is not deemed a medical necessity by the payer.
- 197 – Payment denied/reduced for absence of precertification/authorization.
- T13 – Medical necessity denial. You may submit a request for an appeal/reconsideration no later than 11 months from the date of service.
- 150 – Documentation does not support the level of service required for 98941.
- 50 – Office visits are not medically necessary with every therapy session. Standard medical practice may be one or two visits in addition to therapy treatments. Reimbursement beyond this standard utilization requires documentation supporting the medical necessity.
- 197 – The treatment is outside of or exceeds the ODG, therefore, preauthorization is required.

Explanation of benefits dated January 10, 2012
- B13 – Previously paid. Payment for this claim/svc may have been provided in a prev payment.
- 197 – The treatment is outside of or exceeds the ODG, therefore, preauthorization is required.
- 151 – Per Medicare guidelines, only 1 unit per day, of CPT 98943 may be billed and reimbursed, regardless of how many regions were manipulated.
- 18 – Duplicate claim/service.

Explanation of benefits dated January 11, 2012
- B13 – Previously paid. Payment for this claim/svc may have been provided in a prev payment.
- 18 – Duplicate claim/service.
- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 151 – Payment adjusted because the payer deems the information submitted does not support this many services.
- 197 – Payment denied/reduced for absence of precertification/authorization.
- 197 – The treatment is outside of or exceeds the ODG, therefore, preauthorization is required.
- 151 – Per Medicare guidelines, only 1 unit per day, of CPT 98941 may be billed and reimbursed, regardless of how many regions were manipulated.
- B13 – Duplicate charge(s). Previously audited and recommended for payment. ITN #00545308 Process date 12/12/11

Explanation of benefits dated January 12, 2012
- 18 – Duplicate claim/service.
- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 50 – These are non-covered services because this is not deemed a medical necessity by the payer.
- 151 – Payment adjusted because the payer deems the information submitted does not support this many services.
- 197 – Payment denied/reduced for absence of precertification/authorization.
- T13 – Medical necessity denial. You may submit a request for an appeal/reconsideration no later than 11 months from the date of service.
- 197 – The treatment is outside of or exceeds the ODG, therefore, preauthorization is required.
- 150 – Documentation does not support the level of service required for 98941. Only 1 spinal region documented as manipulated.
- 151 – Per Medicare guidelines, only 1 unit per day, of CPT 98943 may be billed and reimbursed, regardless of how many regions were manipulated.
- 50 – Office visits are not medically necessary with every therapy session. Standard medical practice may be one or two visits in addition to therapy treatments. Reimbursement beyond this standard utilization requires documentation supporting the medical necessity.

Explanation of benefits dated February 7, 2012
- B13 – Previously paid. Payment for this claim/svc may have been provided in a prev payment.
- W1 – Workers Compensation State Fee Schedule Adjustment
- 197 – Payment denied/reduced for absence of precertification/authorization.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.

- 197 – The treatment is outside of or exceeds the ODG, therefore, preauthorization is required.
- B13 – Duplicate charge(s). Previously audited and recommended for payment. ITN #00534301 Process date 12/12/11
- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 151 – Payment adjusted because the payer deems the information submitted does not support this many services.
- 197 – The treatment is outside of or exceeds the ODG, therefore, preauthorization is required.
- 150 – Documentation does not support the level of service required for 98941. Only 1 spinal region documented as manipulated.
- 151 – Per Medicare guidelines, only 1 unit per day, of CPT 98943 may be billed and reimbursed, regardless of how many regions were manipulated.
- B13 – Duplicate charge(s). Previously audited and recommended for payment. ITN #00534304 Process date 12/12/11
- B13 – Duplicate charge(s). Previously audited and recommended for payment. ITN #00534310 Process date 12/12/11
- B13 – Duplicate charge(s). Previously audited and recommended for payment. ITN #00534313 Process date 12/12/11
- 50 – These are non-covered services because this is not deemed a medical necessity by the payer.
- 50 – Office visits are not medically necessary with every therapy session. Standard medical practice may be one or two visits in addition to therapy treatments. Reimbursement beyond this standard utilization requires documentation supporting the medical necessity.
- CPT 98943 Manipulation is not recommended by the ODG for wrist or knee.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on December 6, 2010. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of medical necessity have been resolved as of the undersigned date for the services rendered on October 21, 2011 through November 14, 2011.
2. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 29, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.